Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: EAST HOUSTON MEDICAL CENTER 3701 KIRBY DRIVE, STE. 1288 HOUSTON, TX 77098-3926	MFDR Tracking #: M4-09-A096-01
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO. REP. BOX #: 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "As required by law, the Provider billed its usual and customary charges for the services rendered in this claim. **There was never an on-site audit performed by the insurance carrier. The appropriateness of the medical care was not questioned, nor were any items or services excluded from the claim in question as being "personal items", "not-related" or otherwise excludable on any basis authorized by the payment rules of the Division of Workers' Compenation,** (hereafter referred to as the "Division"). The claim presented by the Provider was billed in the same manner and at the same rates that it would bill any health plan, insurer, or other medical bill payor. There is no evidence provided by the carrier that the disputed charges were not billed at the hospital's usual and customary rate. The issuance of an Explanation of Benefits is not evidence of an audit or proof of the validity of the carrier's reduction methodologies. It represents nothing more than a carrier's re-pricing in lieu of actual audit, with favorable to the carrier substitution of figures. Our client contends that fair and reasonable reimbursement for the services rendered to this injured worker would not be less than $15, 926.13… In closing, it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to improper reductions taken by the carrier in this case…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bills
3. EOBs
4. Medical Reports
5. Total Amount Sought : $7,145.67

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…Carrier asserts that it has properly calculated reimbursement based upon the applicable fee guidelines. Carrier's exclamation (sp) of benefits shows the individual reductions. Requestor has not made any specific complaint as to the Carrier's calculations or submitted any evidence or authority that additional reimbursement is owed. Carrier has audited the billed amount and excluded certain line items already reimbursed under other billable items or is considered under Medicare rule to be bundled in the reimbursement for a related service. These include charge listed under Pharmacy General, Pharmacy IV Solution, Intravenous Infusion, Med/Surgical Supplies, Fluoroscopy, and Vaccine TD. Requestor has not presented any authority that these charges are reimbursable. Requestor has failed to carry its burden of proving that additional reimbursement is owed. Carrier requests that the Division order that no additional reimbursement is owed for this service date…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
07/08/2008	Hospital Outpatient Services	$4,547.32 (APC) +$0.00(Outlier Amount) = $4,547.32 (OPPS) x 200% + $337.97 (Fee Schedule) = $9,432.61 - $8,780.46 (Total paid by Respondent) = $652.15	$7,145.67	$652.15
			Total Due:	$652.15

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 08/25/2008:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate..
   - 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
   - 284 – No allowance was recommended as this procedure has a Medicare status of "b" (bundled).
   - 329 – Allowance for this service represents 50% because of multiple or bilateral rules.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - W1 – Workers Compensation state fee schedule adjustment.

   Explanation of benefits with the listed date of audit 09/16/2008:
   - 226 – Included in global charge.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 329 – Allowance for this service represents 40% because of multiple or bilateral rules.
   - 45 – Charges exceed your contracted legislated fee arrangement.
   - 59 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
   - 618 – The value of this procedure is included in the value of another procedure performed on this date.
   - 770 – Complex bill review.
   - 793 – Reduction due to PPO contract.
   - 89 – Professional fees removed from charges.
   - 97 – Payment is included in the allowance for another service/procedure.
2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources

they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

   (4) According to Rule 134.403, REV codes 301 and 305 (CPT Codes 80048, 80100, 82075, 85730, 85025 and 85610) are paid under a fee schedule or with a prospectively pre-determined rate and reimbursement is allowed. REV Code 450 (CPT Code 99284-25) is considered a clinic or emergency department visit which is paid under OPPS; separate APC payment. The code also requires that a modifier -25 be used. The Requestor attached modifier -25; therefore, reimbursement is allowed.

6. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) a follows:

APC	Outlier Amount	Separate Reimbursement for implantables WAS requested under Rule §134.403		APC + Outlier Amount X 200%	Fee Schedule (CMS + DWC conversion factor)	Subtract Amount Paid by Respondent	Results in additional Amt Due to Requestor
$4,547.32	$0.00	$		$9,094.64	$337.97	$8,780.46	$652.15

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $652.15.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of $652.15 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

		11/10/2009
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

		11/10/2009
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.